STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Governmental Psychiatric Hospitals and Governmental Acute Care Hospitals for the Developmentally Disabled Patients
Disproportionate Share Hospital Adjustment

With the exception of high disproportionate share hospitals in State Fiscal Year (SFY) 1995, the payment adjustment will not exceed the cost of services furnished to Medicaid patients, less the amount paid under the non-DSH payment method under the New Jersey State Plan, added to the cost of services provided to patients who are uninsured for services provided during the SFY, less the amount of payments made by those patients. Thus, the payment adjustment to these providers is the limit established by Section 13621 (g) (1) (A) of the Omnibus Budget Reconciliation Act of 1993 (OBRA 93). A retrospective system will be used to determine the adjustment amounts. Prior year actual patient care related costs and payments from the period with the most current data available will be inflated to the estimated billing period levels*. The result of this calculation, which reflects an annual figure, will be divided and paid in equal amounts on a quarterly basis. Subsequent to the billing period, the estimated amounts will be adjusted (upward or downward) based upon the actual costs and payments applicable to the billing period. In unusual circumstances, where actual payments can not be matched to the applicable service cost, a reasonable estimate of the payment amount will be made.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Governmental Psychiatric Hospitals and Governmental Acute Care Hospitals for the Developmentally Disabled Patients
Disproportionate Share Hospital Adjustment

For high disproportionate share hospitals, the payment adjustment for State Fiscal Year 1995 shall equal 200 percent of the cost of furnishing hospital services by the hospital to individuals who either are eligible for medical assistance under the State Plan or have no health insurance for services provided during the year. These payment adjustments will be determined using the same retrospective system identified in the preceding paragraph with the calculated amount being doubled. This paragraph expires June 30, 1995.

B. Disproportionate share payment adjustments will be made on a quarterly basis.

C. To qualify as a high disproportionate share hospital, the governmental hospital must have the highest number of inpatient days attributable to individuals entitled to Medicaid benefits of any hospital in the state for the previous State Fiscal Year (1994), or the hospital's Medicaid inpatient utilization rate must be at least one (1) standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the state. This paragraph expires June 30, 1995.

* When base year costs or payments (after inflationary increments) do not reasonably reflect the anticipated costs or payments for the payment year, an adjustment may be made to the base year data to reflect the anticipated costs or payments. The anticipated costs and payments are subject to retrospective adjustment.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Governmental Psychiatric Hospitals and Governmental Acute Care Hospitals for the Developmentally Disabled Patients

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TN 94-20 Approval Date AUG 20 1998

Supersedes TN New Effective Date JUL 1 6 1994

STATE PLAN UNDER XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Out-of-State Hospitals

1. The effective date for this State Plan is for services rendered on or after October 1, 1995.

   a) Reimbursement for all out-of-State hospitals will only be for inpatient services that were prior authorized by the New jersey Medicaid program, emergency medical services, transfers and care provided to Medicaid beneficiaries residing out-of-State with the approval of the New Jersey Department of Human Services.

   b) Out-of-State participating hospitals are hospitals with valid provider agreements with the State Medicaid Agency in the state in which they are located.

   c) Reimbursement of inpatient services in out-of-State participating hospitals will be in accordance with the following criteria:

      i) Reimbursement will be 100 percent of the claims specific reimbursement methodology approved by the State Medicaid Agency of the state in which the hospital is located except as provided below.

      ii) Reimbursement of inpatient services provided to an eligible Medicaid beneficiary, who has been determined to be in need of, and approved for, a medically necessary transplant that is not experimental, because of a life-threatening situation, will be 100 percent of the claim specific reimbursement methodology approved by the State Medicaid Agency of the state in which the hospital is located. If this is not acceptable, a negotiated payment amount correlated to the hospital's cost-to-charge ratio between the New Jersey Medicaid program and the hospital performing the transplant will be utilized. If both of the above are not acceptable, the New Jersey Medicaid program will reimburse the hospital the documented usual and customary amount which the hospital receives for all other out-of-State patient receiving the similar type of service.

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Supersedes TN 92-26 Effective Date OCT 1 1995

STATE PLAN UNDER XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Out-of-State Hospitals

d) Out-of-State non-participating hospitals are hospitals without valid provider agreements with the State Medicaid Agency in the state in which the hospital is located.

e) Reimbursement of inpatient services provided in out-of-State non-participating hospitals to an eligible Medicaid beneficiary, who has been determined to be in need of, and approved for, a medically necessary transplant that is not experimental, because of a life threatening situation, will be at 100 percent of the typical reimbursement methodology for that procedure approved by the State Medicaid Agency of the state in which the hospital is located. If this is not acceptable, a negotiated payment amount correlated to the hospital's cost-to-charge ratio between the New Jersey Medicaid program and the hospital performing the transplant will be utilized. If both of the above are not acceptable, the New Jersey Medicaid program will reimburse the hospital the documented usual and customary amount which the hospital receives for all other out-of-State patient receiving the similar type of service.

TN 95-37 Approval Date MAY 08 1998

Supersedes TN 92-26 Effective Date OCT 1 1995

OCT 1 1995

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TN 92-26 Approval Date FEB 10 1997
Supersedes TN 85-35 Effective Date JUL 01 1992
NEW

OUT-OF-STATE HOSPITALS

(Disproportionate Share)

The New Jersey Medicaid Program will not reimburse disproportionate share hospitals located in a state other than New Jersey.

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JUN 30 1997

TN 96-30(b) Approval Date JUN 30 1997

Supersedes TN New Effective Date SEP 2 0 1996

- actually 88-20 processed the same day.

Pages III-~~31~~ 12 through III-~~40~~ 15

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Supersedes TN New Effective Date 7-1-88

G. "Proposed Alternate Rate" is the payment rate developed by applying these rate review guidelines to the elements of cost reported on the 1981 Actual SHARE Forms.

H. "Administrative Payment Rate" is the payment rate developed following a detailed review with the Analyst of the Proposed Alternate Rate.

I. "Final Administrative Rate" is the payment rate developed as a result of:

1. Acceptance by the hospital of the Global Rate, or

2. Acceptance by the hospital of the Proposed Alternate Rate, or

3. Acceptance by the hospital of the Administrative Payment Rate, or

4. The rate established following an appeal to the Hearing Officer from the administrative rate determination.

J. "Final Rate" is the payment rate developed from the Final Administrative Rate following the certification of actual costs of providing health care services as reported by hospitals, by making the retroactive adjustments described under Section 15.

K. "Forms" are the data collection forms which a hospital uses to report actual costs. These forms must be completed using the cost center definitions in Section B of the SHARE Manual, the statistical definitions in Section D of the Manual, and the cost reporting and allocation methodology prescribed in Section E of the Manual. No other allocation method is acceptable.

L. "Schedules" refers to the schedules used to test the reasonableness of actual expenses and to determine reasonable increases.

M. "Level I Appeal" is the appeal held with a Department Analyst. This appeal will be held within 60 working days from the issuance of the Proposed Alternate Rate.

N. "Level II Appeal" is the appeal held before a hearing officer in which the hospital or the payors appeal the Administrative Payment Rate based on the Analyst Review (Level I Appeal). The purpose of the Level II appeal is to determine if the Guidelines were properly interpreted and executed by the analyst at the Level I Appeal based on only information and documentation made available at the time of the analyst review.

4. Time Tables

A. At the request of the Commissioner, hospitals shall furnish to the Department of Health such reports and information as the Department may require to establish reasonable rates for payment by payors for

health care services provided by a hospital, excluding confidential communications from patients. The information shall be used to establish 1983 inpatient per diem rates according to the following schedule:

Activity	Date
SHARE 1981 Actual Submission	April 30, 1982
Projections for 1983 Volumes and other items as required	July 31, 1982
Request for additional Depreciation, Malpractice and Interest to be included in the Payment Rates	July 31, 1982
Global Rate Established	October 1, 1982
Request for 1983 Alternate Rate	November 1, 1982
Form B-2 submitted for Quarter Ending:	
December 31, 1982	February 15, 1983
March 31, 1983	May 15, 1983
June 30, 1983	August 15, 1983
September 30, 1983	November 15, 1983
December 31, 1983	February 15, 1984
Date to submit 1982 actual costs on SHARE Forms	April 30, 1983
Date to submit 1982 Audited Financial Statement	June 30, 1983

B. Hospitals shall submit their 1981 actuals to the Department no later than April 30, 1982. Volume projections, documentation of depreciation and interest costs required for 1983 and other information needed to establish reasonable payment rates for 1983 shall be submitted by July 31, 1982. Any errors in the actuals or supplemental information submitted must be corrected within ten (10) working days of notification of the error. Once the Department has determined that the actual cost submission is suitable for entry into the data base, it shall be so entered; no further substitutions or rearrangement of costs will be accepted unless it is deemed necessary by those performing the detailed, on-site review pursuant to Paragraph E below.

Hospitals that fail to submit the actual costs in a condition that would render them suitable for entry into the data base by June 30, 1982 and/or those that fail to submit volume projections and any other supplemental information in a condition that would render them suitable for entry into the data base by August 15, 1982, shall forfeit their right to proceed under the normal methodology for determining a